Notification of Recipients of Blood and Blood Products – Position Paper
Canadian Society for Transfusion Medicine

Introduction:

The purpose of this position paper is to affirm The Canadian Society for Transfusion Medicine's (CSTM) commitment to promote best practices in Transfusion Medicine by providing information that may be useful for hospitals in Canada who provide Transfusion Services.

Notifying all recipients that they received blood components or products was first recommended in the Krever Commission's Interim Report in 1995.[1] The initial CSA Standards for Blood and Blood Components published in 2003 required hospitals to notify recipients that they received blood and blood components.[2] In a subsequent version of their standards in 2010, they added blood (plasma protein) products to this requirement.[3] The CSTM Standards for Hospital Transfusion Services included this requirement initially in 2004 (Version 1) and then again in 2007 (Version 2) and 2011 (Version 3) such that standard 1.12 now reads, "A Policy shall be established to ensure notification of recipients of blood components and blood (plasma protein) products is provided in writing.[4]

Issue

The value of patients' awareness that they have received a blood product became apparent during the difficult years when an alarming number of patients were found to be infected with HIV or Hepatitis C as a result of transfusion. Since the donors had not been tested, targeted lookbacks could not be done and therefore all recipients of any blood or blood components needed to be informed of the risk and to seek testing. This posed significant challenges, described in detail in the Krever Commission Report:

- Public announcements to inform recipients of the risk and to seek testing could not reach enough recipients since most patients were not aware that they had been transfused.[5]
- Notification was an arduous process. Record keeping practices were deficient, usually on paper and often lacked the information necessary to trace each blood product to the recipient.[6]
- Many lookbacks could not be completed because donors or recipients had moved from the last known address.[7]

[1] Krever Horace Krever, Interim Report, Commission of Inquiry on the Blood System in Canada Appendix H, Chapter 8, page 1134
[2] CSA Z902-04 CSA Standard, Blood and Blood Components, Canadian Standards Association, Mississauga, Ontario, 2004, 11.2.2.
[3] CSA Z902-10, A National Standard of Canada ,Blood and Blood Components, Canadian Standards Association, Mississauga, Ontario, 2010, 11.2.2
[4] CSTM Standards for Hospital Transfusion Services, Ottawa, Version 1 2004: L1.5, Version 2 2007: 1.10, Version 3 2011: 1.12
[5] Krever Horace Krever, Final Report, Commission of Inquiry on the Blood System in Canada (Krever Report) Volume 1, Part III, Chapter 13, Ottawa, 1997, page 362
[6] Krever Report, Volume 1, Part III, Chapter 13, page 348
[7] Krever Report, Volume 1, Part III, Chapter 13, page 349, 359; Volume 2, Part III, Chapter 15, page 473
[8]Canadian Medical Association Expert Working Group. Guidelines for red blood cell and plasma transfusion for adults and children CMAJ 1997;156 (11 suppl).

The Canadian Medical Association (CMA) supported the patients' right to know of any transfusion, in their recommendations, published in 1997, which stated, "Patients should be informed that they have received a red blood cell or plasma transfusion subsequent to its administration." [7]

The Canadian Society for Transfusion Medicine endorses the standards requiring written notification to patients that they have received a blood component or product for the following reasons:

- A patient has the right to know if they are at any risk, associated with the treatment they have received. Although manufacturers of blood components and blood products have succeeded in reducing the risk of contamination of known infectious agents, there still remains some risk of contamination of known infectious agents.[1,2]
- Despite a strong surveillance of adverse events associated with transfusion across Canada, the potential still exists for infection of the blood supply by a new emerging pathogen for which donors have not been tested. In such a situation, patients who are aware of their exposure to blood products could respond immediately to a public announcement to seek testing or treatment. There would still be some delay or failure in contacting recipients through the lookback process, particularly if records are not electronic and/or if patients have moved from the last known address.

Recommendations

To facilitate the process of notification of transfusion, the CSTM recommends the following for hospitals with Transfusion Services:

Processes to ensure recipient notification of transfusion must be developed and implemented. They may be designed according to each patient population concerned and the capacity of the systems and personnel in place to carry them out in an efficient and cost effective manner.

Examples of some notification processes implemented in Canada and associated challenges:

- Systematic notification for chronic patients: If notifications for chronic transfusion recipients will be provided periodically, there should be a mechanism in place for scheduling systematic notification.
- Care unit-initiated notification at discharge: If notifications will be printed from the patient's electronic transfusion file by the care unit at discharge, training of clinical personnel will need to be provided and maintained.
- Lab-initiated notification at discharge: If the Transfusion Service is responsible to send a notification letter for the recipient when issuing, for example, the first blood product during a hospital stay, there should be mechanism to ensure that it is given to the recipient upon discharge or before an outpatient leaves and not given if the product is not transfused.
- Notification by mail: If notifications will be mailed, patients' addresses need to be current and there should be a mechanism to ensure that letters are not sent if the recipient is deceased. An alternate method of notification should be considered for the administration of immune globulin preparations administered as a result of the termination of pregnancy or sexual assault.

Notification of transfusion process(es) should be audited periodically to ensure compliance.

[1]Procédures et interventions en milieu extrahospitalier, Collège des médecins du Québec, ©2011
[2]Code civil du Québec (art. 10)1 1991